Published work
Diogo, C. (2004) *The Reform of the NHS in Portugal.* Working Paper. Department of Management Studies, University of York, York.

University of York
Department of Management Studies
Working Paper No. 5

ISSN Number: 1743-4041

The Reform of the NHS in Portugal

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This paper is circulated for discussion purposes only and its contents should be considered preliminary.

Introduction

The objective of this article is to describe the Portuguese National Healthcare Service, giving a special emphasis to the recent reforms that have been introduced since the beginning of 2002. Its main argument is that there are two different (but connected) rationales that underpin the orientation of the current reforms. One the one hand, the *explicit rationale* that refers mainly to the 'visible' and stated causes and motivations of the reforms. On the other hand, the *implicit rationale,* whose influence over the government's actions is not expressed as such, either because it is not perceived, or because it is not assumed.

For this purpose, it is essential to start by giving an historical account of how the NHS started in Portugal and in which direction it has been evolving in the last four decades. This section has particular interest considering that it gives meaning, together with other arguments, to the *implicit rationale,* to the extent that the current reforms are product of the historical context in which the NHS was created and its subsequent developments.

In the second part, the focus is on the reformation period, that started in 2002 and that is still going on at the moment. The main reforms that are being conducted are analysed, being this section mainly of a descriptive nature. What is considered to be important in this section is to give the government's account of the reforms, in order to make clear what are its motivations and its goals. Furthermore, by doing this analysis it makes it possible to put forward what is meant by *explicit rationale* and identify its features.

In section three, the reforms described in section two are analysed individually in a critical way. The objective of this section is to 'make sense' of the reforms being undertaken by the government and consider some aspects that are still unclear and that need further reflection. It is throughout this section that the main argument of this article is explored, by discussing, when applicable, what is the rationale underpinning the different reforms.

In the conclusion, it is resumed what is the importance of the approached followed in this article and to what extent it can be useful to understand the Portuguese NHS and its future development.

1. Historical background

1.1. The origins and evolution of the NHS in Portugal

The Portuguese Health Care System was created in 1979 and is based on the classical National Health Service model. This model is characterised by universal coverage of the population, generality of benefits, national tax financing and national ownership or control of factors of production (OECD, 1987a).

Before the creation of the National Health Service and to be more precise, before the Revolution of April 1974, the government played a secondary role in the provision of health care, filling gaps left by the private initiative and giving priority to preventive services. Apart from the preventive care expenses (the more specialised curative services such as maternal and child health, certain infectious diseases and mental health) and the civil servants care expenses, the responsibility to pay for health care was left to the individual patient and his or her family (see Table 1.).

Table 1. Percentage of the population covered by a health insurance

	1960	1965	1970	1971-1975
Coverage rate	18%	32%	40%	58%

Source: OECD, Health data 2003

The public expenditure on health was in 1970, 9.92% of the total public expenditure and 1.86% of the GDP, a very low share of gross domestic product if compared to most OECD countries (OECD, 2003b). In fact, most part of the health care services were provided by religious charity hospitals ("misericórdias"), social welfare medical units, health posts or private entities (see Table 2.).

Table 2. Health Institutions in Portugal in 1970

	Gener.	Special.	Total
With hospitalisation	480	154	634
Government	87	84	171
Misericórdias	273	11	284
Private	116	44	160
For profit	-	-	-
Non profit	-	-	-
Other Entities	4	15	19

Source: Adapted from OECD (1994)

By 1970, the main problems in the health sector were: the low standards of health (infant mortality rate of 58% compared to 5% in 2001; 8,580 doctors compared to 33,233 in 2001; etc); the poor distribution of health units and health professionals, with most part of them situated on the urban areas; the lack of co-ordination between the multiple providers of health care services, since they had no relationships with each other; the multiple sources of financing; and the excessive centralisation of some services.

As an attempt to solve these and other debilities of the health sector, a new law, passed in 1971, gave priority to the government over the private sector as a mean to secure a more rational allocation of resources, and aimed to give to the whole population access to a full range of health services. This law included the establishment of the first generation health centres ("Centros de Saúde de 1ª Geração") that embody the preparation of a real National Health Service.

The democratic revolution of the 25th April 1974 (that marked the end of the dictatorial regime) and the new Constitution of 1976 changed Portugal profoundly. Soon after the 1974 revolution the hospitals belonging to the "misericórdias" were taken over by the government as well as the social welfare medical units and the health posts. As far as the district hospitals are concerned, a number of them were rebuilt or upgraded.

New social policies emerged and the creation of a National Health Service was seen as the more adequate response to the needs of the population. Under the new Constitution, all the citizens were given 'the right to health', which was to be

provided by a 'National Health Service which was universal, comprehensive and free of charge'.

In 1979 the National Health Service was indeed created, extending the provision of free health care to all citizens, independently of their social or economic condition. The National Health Service was to be nearly all financed from taxation. The two main providers of health care, social security medical care and the public health services, were brought together under the law that defined the principle of unified direction and decentralised management. Although the NHS claimed to be *universal*, some insurance schemes were left untouched, principally the civil servants scheme that was mainly financed by the government but also by a percentage of the salary of the employee (around 1%). This scheme enabled the civil servants, apart from the access to the hospital system, to go to private doctors and dentists (paid on a fee-for-service basis) and use private clinics and hospitals. Similar benefits were extended to employees of public enterprises (public transports, ports and communications) as well as some special provisions for students, the armed forces, bank workers, etc. So, in practice, these groups had some privileges that the general population did not have access to, which questions the principle of universality of the NHS and to what extent it works in practice.

In 1980, the public expenditure on health was 13.7% of the total public expenditure, which represents an increase of 3.78% in relation to 1970 (OECD, 1994) and the public expenditure rose from 59% of total health expenditure in 1970 to 64.3% in 1980 (OECD, 2003b), as a result of the more intervenient role of the state on the public health after 1971.

The period when the NHS was created in Portugal was characterised by profound political, economical and social changes, marked by the beginning of the democracy and the decolonisation process. These circumstances made the NHS suffer from a series of limitations and weaknesses reflected in: a fragile financial basis and lack of appropriate organisational and management models; difficult access and low efficiency of the public health services; lack of transparency between public and private interests. The limitations associated with the context where the NHS was

created, as well as the inability of the political system to deal with them, marked all its subsequent development.

Due to these limitations, in practice it was very difficult to implement some of the modifications introduced by the 1979 law. The difficulty in establishing the boundaries between the public and private sectors, conducted many Portuguese to use simultaneously more than one health subsystem, according to what they perceive to be better in a particular situation given the alternatives at their disposal. In general, this situation involves opting for private providers, where they usually have to pay fees and later are reimbursed partially or fully by the Ministry of Health. So, the state is paying for services that could be provided inside the NHS without additional costs.

Additionally, most part of the doctors worked both in the private and the public sectors, which resulted in a deficient dedication to the public sector, where the salaries were low compared to those in the private sector. As a result, there was a generalised dissatisfaction with the public sector and the perception that a higher health care quality was provided by the private sector. In fact, in decade of 1970, as it was already mentioned, the total number of doctors was 8,580, from which 5,169 were general practitioners and 3,451 were specialists (OECD, 1994). The total population was 8,680,000 so the ratio was approximately of 1 doctor per 1,000 population. As the number of doctors was so small, they were in a position where they could maximise their income by working in the private sector once there was a big demand for their services. By that time, the doctors were seen as a very valuable resource and there was no way they could be exempted to work in the public service, even if it was acknowledged that they were not doing their work with total dedication. For this reason, their strategic position in the NHS was a very strong one and that will have repercussions on subsequent development.

In 1982, as an attempt to increase the efficiency of the NHS, the Regional Health Administrations (RHAs) were established: 18 districts were created, correspondent to the administrative division of the country. The money flows from the Ministry to these RHAs that are responsible for implementing the health policy within their region. Their main responsibilities are to collect data, inspect and control professional activity, plan and evaluate the services and set up the contracts with the agencies

outside the NHS. This measure revealed to be inappropriate due to the difficulty of the Ministry of Health in coordinating a considerable number of Regional Administrations (18), General-Directorates (5) and Institutes (7). Consequently, a new law passed in 1993 (Decree Law no. 11/93), established that the 18 Regional Health Administrations were to be substituted by 5 Regional Health Administrations, which are subdivided into 18 Sub-Regions of Health.

A new government ruled Portugal from 1985 to 1995 and some of the actions undertaken reflected its right wing ideological option. The legislation of 1990 ("Lei de Bases da Saúde") redefined the mission of the NHS towards a broader concept of health care systems. This was to be achieved through a bigger incentive in the creation of private units of health care services, provided that they were licensed and inspected by the government. Furthermore, the private management of health institutions was encouraged (especially in the public health centres and public hospitals) and the government was willing to facilitate the flow of the human resources from the NHS to the private sector.

It was not before legislation approved in 1993 that some of the measures described above took place. One of them, as it was already mentioned, was the establishment of 5 health regions with maximum autonomy: North, Centre, Lisbon & Tagus Valley, Alentejo and Algarve. These Regional Health Administrations are responsible for the local implementation of national health policy objectives, allowing both a better allocation of resources and a better co-ordination between the different health units. Another important issue was related with the possibility of the doctors that work in the public service in a full time basis, to have professional activity in the private sector as far as this does not interfere with their NHS responsibilities.

In 1995, a socialist government came to power and with it, a new reform of the health care system. In fact, the NHS reformation process was most part of the times related with new political cycles, regarding that the health sector has being seen by the politicians as a priority. In this context, the new reform was based on the principles of what was called "new public management", characterised by the following aspects: first, transformation of the management models of the public hospitals and health centres towards a more flexible and autonomous model of management, characteristic

of the private companies (it was decided in 1996 that all the hospitals should follow this model). Second, expansion of the quality systems with the creation of the "Institute of the Quality in Health". Third, creation of two new medicine schools and reinforcement of the research centres in health sciences as an attempt to increase the quality of the human resources. Fourth, establishment of "contract agencies", an autonomous part of the Regional Health Administrations, which role is to make the contracts with hospitals, health centres and independent groups of doctors, in a first attempt to promote the separation between providers and purchasers, as well as to increase the citizen participation in health decision-making. And fifth, implementation of programs to reduce the waiting lists for surgeries and the creation of the user's card ("cartão do utente") - an identification card containing the patient's name, address, date of birth, and other data, that should be presented every time the patient uses any NHS service.

Another important aspect was that, since 1997, the retrospective hospital budget, based on historical data, was substituted by a prospective budget, based on elements related to production costs, i.e., budgets are based on predicted costs rather than an historical budget (1999 was the first year of budget negotiations based on contracts). There were as well some initiatives concerning the pharmaceutical policy (especially after 1998), mainly: the incentive to the prescription of generics, the low price of the generic drugs (35% less than the other similar drugs), the promotional actions informing the consumers about the economical advantages of buying generics, the incentive given to the national pharmaceutical industry to produce them, etc.

2. Reformation Period

2.1. From 2002 onwards

After the elections of 2002 a new political cycle was initiated with the change of government. This year was characterised by high uncertainty about the international economical evolution, after a phase of general growth. In Portugal, after a period of strong economical expansion in the second half of the 1990s, the GDP increased only 0.4% in 2002 compared to 2001 (OECD, 2003a). At the same time, new pressures for change emerged as the public debt substantially exceeded the 3% ceiling allowed by the EU Stability Pact (Observatório Português dos Sistemas de Saúde, 2003).

The state is currently under pressure to cut public spending and to implement structural reforms. Health, education and social affairs, accounted for more than 60% of general government expenditure in 2001 and the public expenditure on health (as a percentage of GDP) was 6.3%, which is slightly below the OECD average[a] (6.5%) but above the Euro Area average (6.0%) (OECD, 2003b). Moreover, traditionally the Portuguese NHS performs poorly in terms of efficiency, accountability and cost containment. In 2001, the *OECD Economic Survey of Portugal* highlighted the main problems of the public health system and sources of spending pressure. According to this report, there are different factors contributing to it: overlapping insurance schemes, lack of management flexibility and accountability, inadequate co-ordination between public health institutions, an inefficient system of doctors' remuneration, and insufficient competition in health provision and in the sale of pharmaceutical products (OECD, 2001b).

Facing this scenario, the government defined a 'New National Health Care System' to be implemented during the period 2002-2006 (Governo da República Portuguesa, 2002) as an attempt to improve these deficiencies. The reforms will direct the NHS into a "mix of health services, where public, private and social entities coexist and act in an integrated manner, directed towards the needs of health care users" (Ministry of

a. Due to lack of data availability, Korea, Luxembourg and Turkey are excluded from OECD average. Luxembourg is also excluded from the Euro Area average.

Finance, 2003). In this way, the patients will be able to choose the more appropriate services to fulfil their particular needs and that will, according to the government, improve the provision of qualitative attendance to the citizens with effectiveness and humanism.

As main changing tools, the government proposes: i. the development of partnerships with the private sectors, the so called public/private partnerships (PPP); ii. the end of the waiting lists in surgeries and consultations; iii. to provide each citizen with a family doctor; iv. the transformation of public hospitals into companies; v. the adoption of alternative management models, specifically more entrepreneur models ("novas soluções de gestão"); vi. the development of the continuous care network; vii. the creation of a new entity to regulate/control the new changes introduced with the participation of the private and social players in the provision of public health services (called "entidade reguladora da saúde"); viii. improvement of the information systems network and creation of a 'call centre'; ix. modifications on the pharmaceutical policy (specially the drugs' policy); x. changes in the human resource policy; xi. re-organisation of the emergency services.

The task that the Portuguese government is undertaking is an enormous one. At this stage, not all the previously mentioned actions have already been initiated, some because the implementation strategies have not yet been finalised, some other because they involve the production of new regulations that need, first, the approval of the parliament and then the agreement of the President, which is a relatively long process.

Not all the forthcoming implementations described above will be analysed next. Instead, it was decided to describe in more detail the ones considered to be more relevant, in the sense that they involve bigger changes and can create more 'visible' consequences for the future of the NHS.

Public/Private Partnerships (PPP)

The Public Private Partnerships (PPP) are seen as a privileged tool for the renewal of the NHS and to obtain further gains in terms of efficiency, because they are based

upon the transference of risks to the private performers and the transference of the effectiveness of the private sector into the public sector. The PPP were established through the Decree-Law no. 185/2002, August the 20th, and it is the intention of the government to launch ten hospitals (two new hospitals and 8 substitutions) that will enter gradually into operation as from the end of 2007.

The two main advantages identified by the government in respect to the PPP are that they assure gains to the user of the NHS, as well as to the public finance. In practice, on the users side, there would be more satisfaction because they see their capacity of choice of a health care provider increased; on the government side, they transfer the risk of investment to the private sector, as well as they benefit from the experienced management models and tools of the private sector that being under the market pressure will have more motivation to be efficient.

In summary, the government considers the PPP to be a form of improving the financial situation of the NHS (or at least not to complicate it more), while assuring the provision of quality health care to the citizens in an equitable way. So far, none of the PPP initiatives planned by the government has already started. Furthermore, the government has not yet produced the regulation about the specific characteristics of the public/private partnership contracts. Nevertheless, there is already an experience in Portugal of PPP in the health sector. That concerns the management contract made between the Ministry of Health and the Hospital *Fernando da Fonseca*, which should be studied and systematised in order to learn some lessons for the future. This particular case shows that the initial contract was not clear and objective enough, so there are some deviances that do not benefit the desired transparency of the partnership. Furthermore, the monitoring and control mechanisms that should be enforced by the state are also insufficient, which creates some suspicions about the quality of the services and the way the hospital is being managed.

However, according to the National Institute of Administration (INA), the Hospital Fernando Fonseca is a lucrative hospital, mainly because it has a more efficient management of the human resources, since it provides the same services as others but using fewer personnel. The superficiality of the studies made about this particular

experience of PPP does not allow us to undertake definitive conclusions about its efficiency.

Waiting lists

One of the priorities of the government for enacting the reform of the NHS is to increase the access of all citizens to health care. One of the bigger problems identified in this respect are the waiting lists in surgeries and consultations. Long waiting lists have always been a problem and, as that until now an effective way to deal with them was not found, the number of people waiting have been increasing more and more across the years as a result of the bad organisation of the services and the low productivity of the professionals of the NHS, amongst other reasons.

The programme that was initiated in 1998, aimed an increased access to health care services. In April 2002, the government decided to restructure that programme and set a more ambitious objective, in what was called the *Special Programme for Combating the Waiting Lists* (PECLEC). The main objective was to finish all the waiting lists until September 2005 and the means to accomplish it are: i. to establish a form of attendance for patients in a 'first in first out' model, excluding the urgent cases that would have priority; ii. to promote the utilisation of the private and social services; and iii. to increase the organisation of the services in order to optimise the patients attendance.

The PECLEC was initiated in June 2002 and by then, according to the Ministry of Health, there were 123,126 patients waiting for a surgery. From the 1st July 2002 to the 15th August 2003, 7,500 new patients were added to the waiting list per month and 6,700 surgeries were performed per month. If we consider these results, we can see that, in fact, the waiting list for a surgery has been increasing, with the total number of patients being 154,726 in 15th August 2003, compared to the 123,126 in June 2002. The reason presented by the government to explain this fact is that the number of consultations in the new hospital companies increased by 200,000. Thus a higher number of patients got a diagnose to their condition.

The first target set by the government was to end with the initial waiting list of 123,126 cases by the end of February 2004; and from March 2004 on, all the surgeries are to be made in the "clinically accepted length of time" (this depends on the type of surgery). On the 10th December 2003, in an intervention in the Parliament, the Minister of Health announced that from March 2004 on, if a patient is waiting for a surgery more than the "clinically accepted length of time", he or she has the right to request a 'voucher' and to use it in any public, private or social provider of health care, inasmuch as that entity has an agreement with the state. This will transfer the decision of doing a surgery to the patient.

The reason why it is considered important to shift the decision to make a surgery to the patient is because, according to the Ministry of Health, 20,000 patients refused surgeries in the private sector since the beginning of the PECLEC (LUSA, 2004). So, this measure implies that 20,000 patients will be taken out of the waiting list. There are two different perspectives to interpret this action: the first is that it aims solely at the reduction of the number of people in the waiting lists, for political reasons. The second is that, there is the possibility that some of the people in the waiting lists might have already done a surgery in the private or social sectors without informing the NHS, and that may cause disruption in the services.

Not before March 2004 (first target established by the government) the result of the PECLEC will be assessed and to what extent there will be less people on the waiting lists. It is as well relevant to note that in the law approved in the parliament in 1999 about waiting lists (Law no. 27/99, 3 May 1999), it was stated that every 2 months a report should be presented regarding the current situation of the waiting lists. Nevertheless, there is no record of any report being presented in the last year and that did not raise any worry in the different political actors.

Hospital Management Reform

Traditionally, Portuguese public hospitals perform poorly in terms of efficiency, accountability and cost containment. An evidence for this is that historically, the actual health expenditures usually exceed considerably the budget limits, requiring the

approval of additional budgets (Dixon and Mossialos, 2000). According to Monica Oliveira (2002) some reasons for this are: first, doctors have little incentive to be productive in public hospitals - as their payment system is based on salaries, productivity is not rewarded and doctors maximise income by doing overtime in NHS hospitals and working in the private sector; second, hospital administrators are not encouraged to operate within budgets, because they are not penalised for overruns; third, hospital administrators have little decision-making autonomy as far as the control of investment and human resources is concerned.

Despite protests from key stakeholders, a new hospital management law was passed through Parliament in September 2002 (Law no. 27/2002). The new law follows similar trends in other countries, by moving NHS hospital management structures away from a single-category of public status, to one where public entities coexist with private entities acting in a cooperative way and having as common objective the fulfilment of the patients' needs. These reforms have significant implications for the future of hospitals in Portugal.

The new hospital management law required the amendment of the 1990 NHS Law and targets two objectives: improving efficiency and accountability and avoiding potential withdrawal of services resulting from any potential lack of financial resources. The main alterations introduced by the law are:

1. A change from the collective negotiation of health professionals' contracts to individual labour contracts.

2. Changing the concept of the 'NHS hospital' to the new concept of 'Network of health care providers', which includes four types of hospitals (Observatório Português dos Sistemas de Saúde, 2003):

    a) Public providers with financial and administrative autonomy but under public management;

    b) Public providers with administrative, financial and asset management autonomy, under (contracted) private management;

c) Providers under corporate law, with equity shares and the State as the exclusive shareholder. The state owns their capital via numerous public agencies that act as statutory shareholders (called 'hospital companies').

d) Private providers contracted by the State.

3. Other changes such us the introduction of performance evaluation, funding by activity related payments and establishing freedom of choice of provider for patients.

According to the Portuguese Department of Health, the objective of these reforms is performing a shift from a bureaucratic and monopolistic health care system to a system that is strongly orientated towards the satisfaction of the patient/customer needs and characterised by the existence of multiple providers.

'Hospital Companies'

Among the 4 possible types of hospitals presented under the new law, the 'Hospital Company' was the option preferred by the government, even if it is the most autonomous of them all. In the beginning of 2003, a new enterprising model was implemented, transforming 34 public hospitals (about 1/3 of the total number of public hospitals) into 31 anonymous societies ('hospital companies') exclusively with public capital and a management board constituted by public managers (Ministry of Health, 2003).

The aim of this alteration is to simulate a market for the hospitals so that the NHS might be free to purchase services both in the public and in the private sector. Simultaneously, the Department of Health promotes the functional separation between the purchaser and the provider of health care, arguing that such separation will better assure the provision of care, based on the premise that an increase in competition will lead to better quality of services.

Ideally, the transformation into corporate entities should enhance accountability and efficiency. A few pilot programmes where either public hospitals have incorporated private practices in cost management, or hospitals are privately run, show that costs can be reduced. Two examples are those of Hospital Nossa Senhora do Rosário and Hospital de São Sebatião. In the first case, it was possible to obtain efficiency gains by making each director fully responsible for the management of his service (introduction of middle management). An activity based-costing (ABC) was established to each service, so that comparisons can be made, benchmarks established and inefficiencies identified. Another objective of the strategy implemented in Hospital Nossa Senhora do Rosário was to break up the resistance of doctors and nurses to changes in their traditional working environment.

In Hospital de São Sebastião, the introduction of individual labour contracts allowed the hospital to reduce the costs with the professionals that, by their own initiative, chose to have an individual labour contract based on individual performance (around 80% of the total professionals in 2000). This gave more flexibility to the managers in terms of organisation of the services and kept personnel spending below the average of other public hospitals of the same size in the region (Ministério da Saúde, 2003).

People with responsibilities in the health sector, the academic community and the public feel that although it was necessary to change the *status quo*, the option of the government in adopting an enterprising model in such a large number of hospitals is neither sufficiently supported by in-depth studies of the Portuguese health sector nor based on evidence of successful experiences performed in other countries (Observatório Português dos Sistemas de Saúde, 2003).

The government has a different opinion and the Minister of Health, in an interview given on 10th December 2003 (Costa and Costa, 2003), announced that, comparing the first 9 months of 2002 with the first 9 months of 2003, the hospital companies increased the number of surgeries by 20%, the number of consultations by 9%, the day care treatments by 15% and all these using less resources than before.

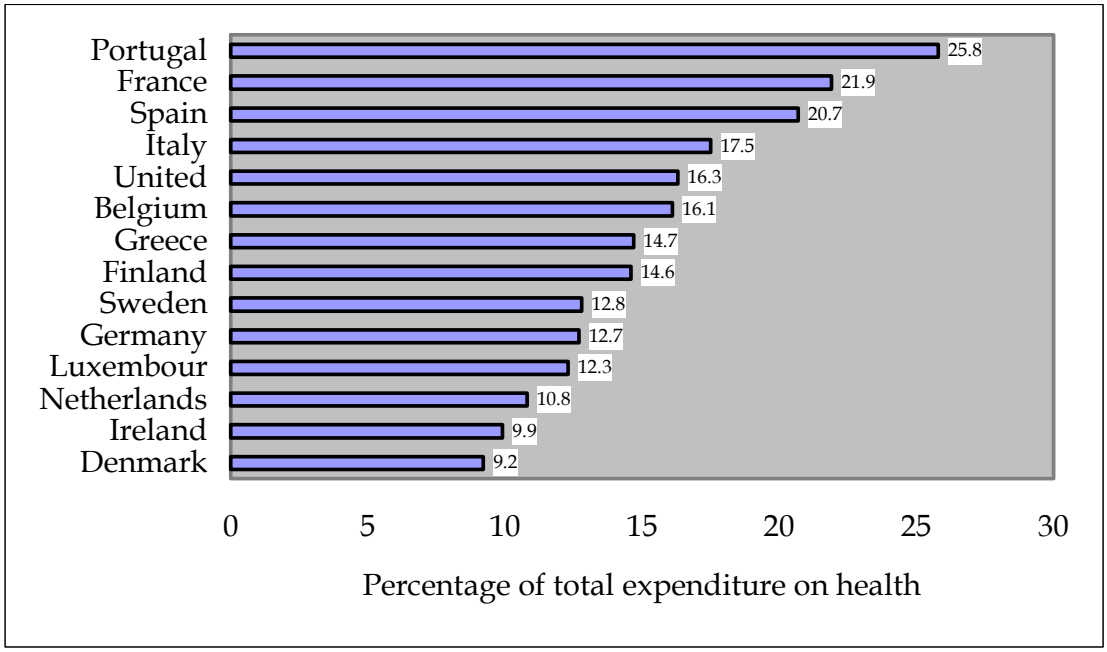
Now the hospitals seem to put more effort in containing costs because they have activity plans based on multi-annual contract programmes, agreed upon with the

Ministry of Health. These contracts introduce qualitative and quantitative targets, scheduling, investment needs as well as performance indicators. They also involved the monitoring of quality and they refer only to the provision of health care to the NHS, thus not including the provision of services to other health subsystems or health insurances. The payments that the Ministry of Health does to the hospitals for the services provided, are based upon contracted production levels with an upper margin of 10%; payments above this margin are based on the marginal costs. The hospitals have an extra incentive to contain expenses, once the overruns that were covered by adjustments to the initial budget in the past, will no longer be. Apart from the contracts with the state, they need to attract new patients/customers, whether they are individual patients or other purchasers of health such as health subsystems, health insurances or other agents. In summary, the hospital companies, similarly to any other player in a market, need to be competitive, based on elements such as: efficiency, quality and price, amongst others.

Modification of the Pharmaceutical Policy

In the last years, the pharmaceutical policy in Portugal has been oriented by a strong attempt to control the continuous growth of the expenses in the sector. It is consensual that it is urgent to stop the expansion of the costs that the government has with medicines, which is an area of recognised waste of resources. In 1997/1998, 25.8% of Portugal's total health expenditure was on pharmaceuticals, which is the highest percentage between countries of the EU (see Graph 1). Since 1998 this sector was object of some renewals, but it was mainly after 2002 that more specific actions were undertaken in order to improve the accountability of the pharmaceutical sector.

Graph 1. Expenditure on pharmaceuticals as a share of total health expenditure in the EU countries, 1997/98



Source: Adapted from OECD (2001a)
* Due to lack of data availability Austria is not included

Several campaigns were carried out in order to call the attention of the public to the economic benefits in buying generics, regarding that they are cheaper than the other medicines and have the same quality. Other measures carried out include: the pricing of generics at least 35% below the price of the reference product; the subsidisation of generics by the state, 10% more than the other "traditional" medicines; the prescription of medicines needs to be done by Common International Denomination; the introduction of the price referral system (PRS) with cost-sharing based on the price of the most expensive generic; the support to the pharmaceutical industry for R&D activities and technological development; the adoption of a new medical prescription model, with the inclusion of the modality of renewal medical prescription; and the development of an information system.

This reforms lead to a significant increase in the use of generics, whose market share rose from 1.27% in the first semester of 2002, to 6.2% in the same period of 2003

(Ministry of Finance, 2003). In terms of sales, the value of generics sold in 2003 was, 111 million euros, three times more than the 33 million euros sold in 2002.

As a consequence of the increase of the generics' market in Portugal, the public expense with medicines has already decreased, regarding that the amount that the state pays to the pharmacies to cover the subsidies decreased as well. The Ministry of Health underlines that the savings are going to be bigger than initially forecasted, not including the savings of the families that, now, buy generics. Apart from these more direct effects, the introduction of generics into the market has other consequences, related to the need of the laboratories to decrease the price of the medicines they sell, if they want to remain competitive.

In general terms, the introduction of generics into the pharmaceutical market, more than contributing to the reduction of the expenses of the public sector with medicines, has an essential role in the design of a policy that aims the rational use of medicines by the citizens. Portugal was in 1998 one of the countries with higher expenditure on pharmaceuticals per capita (US$ PPP) with $310, only surpassed by Belgium ($318) and France ($447) amongst all the EU countries (OECD, 2001a).

Changes in Human Resource Policy

Huan resource policy was identified by the government as one of the areas of inefficiency in health care. The remuneration system for physicians is considered to be one of the causes of the spending pressures, regarding that doctor's remuneration is linked to professional category and length of service, irrespective of productivity. The deficit of health professionals and the asymmetry in their regional distribution is another problem identified by the government. The concentration of doctors and nursing personnel in the coastland health facilities namely in Oporto, Lisbon and Coimbra, led to problems of scarcity of these professionals in the suburbs.

To address these and other issues, the government intends to implement different measures. One is the development of an integrated information system that would enable a continuous update of the characteristics and distribution of the personnel, in

an attempt to promote a better allocation of resources. Another measure is to engage in a partnership with the Ministry of Education in order to propose measures for the resolution of health lacks on a short medium basis, mainly by increasing the number of students that each year go into the Universities to do a course in medical sciences. In fact, according to data from 1995, Portugal was the EU country with the lowest ratio of health care personnel (physicians and nurses) entering the workforce, per 100,000 population (Dixon and Reis, 1999).

It is also urgent that the areas where there is need for a specific type of professionals are identified, and subsequently find solutions more adjustable to the real needs of each region. This could be achieved, according to the government, through the approval of a project, which contemplates incentives to the doctors working in services or areas that suffer from shortages.

A final proposal of the government is to develop new models of remuneration based on the performance. This issue is related with the new judicial regime of hospital management approved by Law no. 27/2002 and the subsequent transformation of public hospitals into hospital companies. This change involves the possibility of the personnel in opting for individual contracts based on productivity and efficiency. The government sees here a possibility of reducing the costs with salaries that account typically for 80% of hospitals' current outlays (Bronchi, 2003). This measure would also be a disincentive for doctors to divide their working hours between the public and the private sector, once their remuneration in the public sector is no longer a "fixed" salary.

The main reforms initiated in 2002, when the current government started its governance, have been described. As it was mentioned, the political motivation of the government was essentially financial, to the extent that Portugal was under pressure to reduce its public debt in order to accomplish with the Stability Pact.

Now that the criteria in which the Ministry of Health and the Government based their decisions when introducing the reforms were presented, it is important to assess what are the possible drawbacks or benefits that may arise, as well as integrate the

described reforms in the rationales introduced in the beginning of this article: the *implicit rationale* and the *explicit rationale*. Nevertheless, it should be kept in mind that some reforms have not yet been initiated and some others are so recent that major conclusions cannot yet be drawn.

3. Discussion

It is undeniable that the Portuguese NHS needs some intervention in order to become not only better in terms of accountability and cost containment but also in terms of the reorganisation of its practices. Some issues that seem to be unclear deserve further reflection and that is what this section aims at.

In order to make it clearer to the reader, the structure to be followed will be the same as that of the previous section, where the main aspects of the reforms will be analysed one by one, discussing possible links between them.

But before this, a short reflection on the concepts of *implicit* and *explicit rationale* will be made, once they will be used throughout the section, every time it is considered to be relevant.

3.1. *Implicit Rationale* and *Explicit Rationale*

It is important at this point that the concepts defined in this paper as *implicit* and *explicit rationale* are introduced, in order to contextualise the ongoing reforms. If the motivations of the reforms are identified and if they are understood in the broad framework of the Portuguese NHS since its origin to the present, it is more likely that more meaningful reflections about the future developments of the NHS can be made.

3.1.1. *Implicit Rationale*

The *implicit rationale* concerns mainly what was described in the section 1 of this paper. The history of the NHS, starting with the circumstances in which it was created, the way it evolved, until the moment the current government decided to implement these reforms, has a very important role to play in the decisions that were made.

There are three main elements that are identified as making part of the *implicit rationale*. The first one is the conjunctural situation in which the NHS was created. As it was already referred, the NHS started in a pos-Revolution period, where the country

moved from several years under a dictatorial regime to a democracy. The years after the 1974 revolution were marked by euphoria and some instability and so the circumstances in which the NHS was created made it suffer from several limitations (as described in section 1), mainly the lack of appropriate organisational models, a fragile financial basis and lack of transparency between public and private interests.

The second element, closely related to the first, is the political ideology of the different governments that have been determining the evolution of the NHS. As it was mentioned in section 1, it is evident that depending on the political ideology of the government, the practices change and the instruments used to interfere with the way the NHS is being run change in the same way.

The third and last of the elements here identified as making part of the *implicit rationale* is the 'institutional power' that doctors have. Since the creation of the NHS that doctors have a rather powerful position not only within the organisations where they work, but also as an organised professional group with a very active political intervention. It is complex to find a single explanation about when this position started or how is it maintained. Nevertheless, and for the purpose of this article, there is one important point that needs to be made and that is related with the fact that most part of the doctors that entered the NHS when it began in 1979 are still part of it now. Considering the importance they were given in a time where they were a very valuable and scarce resource, it is difficult for them now to foresee the possibility of having a 'downgrade' in their status; not in terms of professional career but in terms of changes in some managerial practices that can have consequences in their privileges. For these, and other reasons, the generality of the doctors are considerably adverse to change.

The importance of the *implicit rationale* is that it influences the decisions made by the government and the reforms that were decided to be undertaken, although it is not identified as being a motivation of it. To a certain extent, the *implicit rationale* is a tacit element of the reforms. Because it was not announced as such, doesn't mean that it doesn't play an important role in the way the NHS is now being transformed. It is claimed on this paper that the *implicit rational* does make part of the motivations that

are behind the reforms, as it will be discussed in section 3.3 of this article, together with the *explicit rationale* that will be describe next.

3.1.2. *Explicit rationale*

Contrary to the *implicit rationale*, the *explicit rationale* refers mainly to those elements described in section 2, which the government identifies as being the causes of the reforms. They have mainly a financial dimension, motivated by the problems Portugal had in 2002 to maintain the public debt under the 3% limit allowed by the EU stability pact.

According to the government, improved accountability, cost containment and more efficiency are some of the guiding lines of the reorganisation of the NHS to be carried out in the next years, always keeping in mind that the ultimate mission of the NHS is to provide the citizen with qualitative health care.

These are, therefore, the elements that compose the *explicit rationale;* the ones that are articulated and assumed by the government as being the motivation of the reforms.

3.2. The Reforms

Public/Private Partnerships

It is mainly based on what was identified as *explicit rationale* that we should place the creation of the PPP. The reasons of the government to launch this initiative are mainly related to the improvement of the accountability and the financial problems that are faced by the majority of the public hospitals. Nevertheless, it also considerable the influence of the government's political orientation in the decision of creating PPP opting, not only in the health care sector, to give to the private organisations the opportunity to enter markets that have been, until now, mainly dominated by the state in order to make these markets more competitive and the organisations that 'play' in

them more efficient and cost aware. So, also the *implicit rationale* influences directly this initiative.

Until the present moment none of the 10 PPP announced by the government have been initiated. As it was mentioned in the previous section, there is one PPP experience in the health sector with *Hospital Fernando da Fonseca*, which has already caused some problems to the government, because the initial contract was not clear enough and complete enough to avoid some inaccuracies, especially as far as mechanisms of supervision and monitoring are concerned.

It does not seem that the origins of the above mentioned problems have been identified and studied in depth by the government, which would be necessary in order to avoid similar problems in the forthcoming experiences. In fact, although the European Investment Bank has been emphasising the importance of doing PPP in the health sector (as well as in other sectors), the experiences in other countries provide little evidence for the benefits of introducing PPP and the debate is controversial.

In order to make the PPP a success in Portugal by extracting all the positive effects of transferring the investment risks from the public sector to the private sector, and the effectiveness of the private sector into the public sector, it is fundamental to conduct thorough studies adapted to the reality of the Portuguese NHS and not only to import solutions adopted in other countries. In addition, it is necessary to define clearly the contracts that are going to be made with the different private or social partners to avoid potential negative externalities (e.g. financial decontrol, adverse selection).

Waiting Lists

The government strategy concerning the waiting lists is, I believe, the more ambitious of the reforms, together with the transformation of 34 public hospitals into 31 hospital companies.

Both the *explicit* and *implicit rationales* are behind this reform. The first, because long waiting lists involve very high costs and this situation requires intervention. The second, because the present situation is the product of several years of a disorganised

system without a clear strategy, which resulted in a big list of people waiting for surgeries or consultations – the origin is the conjunctural situation in which the NHS was created.

The commitment made in April 2002 by the Ministry of Health, to finish with the initial waiting list by March 2004 (the waiting list that existed when this government initiated the reform), and with all the waiting lists by September 2005, was, certainly, a very ambitious one and an enormous challenge. Especially if we consider that some of the tools to be used in order to achieve this objective were still not put into practice or at least not yet fully implemented. For instance the hospital companies, whose increased efficiency played a big part on this, as well as the changes in the human resource policy.

In fact, when the hospital companies finally started their activity, the number of consultations increased and consequently there were more patients diagnosed to do a surgery. As it was mentioned previously, this situation led to an increase in the number of patients waiting for a surgery. The Ministry of Health was probably not expecting this outcome and the solution found to face it was to announce, last December, that from March 2004 on, people waiting for a surgery more than the clinically accepted length of time, could go to any private or social provider that has an agreement with the state, and do the surgery there. The users of the NHS are not satisfied with the services they are being provided and the waiting lists for surgeries are probably the main focus of the user's claims. For this reason, the government is really under pressure to make some changes, not only because of the dissatisfaction of the patients with the length of time they need to wait for a surgery, but also because keeping these patients on a waiting lists for several months involves high costs. During the time they are placed on the waiting lists, they keep on having consultations and doing exams that are most part of the times very expensive, and all the costs are charged to the NHS.

This situation seems to be, at first sight, very good from the patients' point of view. From March on, they will have the possibility to make the surgery quicker than if they were kept in the waiting lists and all this with no additional costs. But in practice, if the patients opt for this solution, they will, most likely, need to travel to the place

where they are going to be treated, regarding that most part of the private and social providers of health care are located in the urban areas of Oporto and Lisbon. There are inclusively some contracts made between the Ministry of Health and health care providers in Spain, in which case the inconvenience caused to the patients is even bigger.

Although this measure emphasises the principle of universality of the NHS, there persist some doubts about how it assures the provision of free health care. Furthermore, it is also not clear whether this measure will contribute to the containment of costs aimed by the government and increased efficiency of the NHS. So far, and after the announcement of this reform, the Ministry of Health did not give further explanations about the strategies and tools that support it. It is important that the government provides data on the financial benefits of opting for the voucher scheme to finish with long waiting lists and to what extent it will not only benefit the patient, but also increase the efficiency of the services.

The main reasons to the definition of the 'New National Health Care System' were to improve accountability and efficiency of the services, while assuring quality of attendance to the patients. The strategy followed by the government, as far as waiting lists are concerned, shows some difficulty in co-ordinating these two dimensions: efficiency and cost containment on the one side and quality of services on the other.

This last solution, of introducing a system similar to a 'voucher scheme', addresses the objective of increasing quality (with some limitations as it was already said), but there is no evidence that it will also be positive in terms of efficiency and cost containment. Furthermore, this measure appears to be a response to the critics made by the civil society and particularly by the political parties with representation in the parliament, that the government was only concerned with accountability, cost containment, efficiency and measurement, forgetting the foundations of the NHS as an universal, comprehensive and free of charge system. If this is the case, the motivation appears to be a purely political one, underpinned by electoral motivations.

'Hospital Companies'

As it was described earlier, the hospital management reform introduced the following main alterations: change from the collective negotiation of health professionals' contracts to individual labour contracts; changing the concept of the 'NHS hospital' to the new concept of 'Network of health care providers' (4 types of hospitals); and other changes such as the introduction of performance evaluation, funding by activity related payments and establishing freedom of choice of provider for patients. At this point, we will only focus on the second alteration, more precisely on the creation of hospital companies in the Portuguese NHS because it was the option preferred by the government and the one that is generating more discussion.

With the creation of the hospital companies, the government's intention is to introduce competition into the hospital market as a mean to increase efficiency and quality of the services provided and, consequently, the patients' satisfaction. It aims as well, by the separation between purchasers and providers, to have freedom in purchasing health care both in the public and in the private sector. Similar experiences were already made in other countries (for instance the introduction of quasi-markets in the English NHS) and little evidence seems to support this 'experiment'. Some studies conclude that the impact of competition is the reduction of quality in hospitals (Propper *et al.*, 2003), which is the opposite effect from the one expected by the Portuguese government.

With the introduction of competition into the hospitals' market, the Portuguese government aims also at cost containment, since the hospitals would need to improve its resource allocation in order to attract the customers' attention and make contracts with the purchasers. But it is important to note that the measures to increase resource allocation can be themselves costly and sometimes even more costly than the savings they create (LeGrand, 1991). Examples might be as distinct as spending on advertisement or the need to pay higher wages because hospitals will be competing for doctors, nurses, etc. However, wage rises may have a positive effect on the staff's morale and lead to an increase in productivity. It is imperative that these elements are taken into consideration by the administrations of the 31 'hospital companies', which

are acting under a competitive environment and whose performance is being evaluated.

One of the criticisms that has been made to the creation of the hospital companies is that there is the danger that the hospitals start to 'choose' the type of patients whose treatments involve low-cost procedures and reject those patients who are in conditions that require expensive treatments. The name given to this type of behaviour is *cream-skimming*, and that is one of the bigger menaces to the principle of equity. The government needs to enforce mechanisms of control and supervision in order to avoid *cream-skimming*, and other dangers that can emerge.

The monitoring and supervision task is a complex one, once there are 31 hospital companies already operating. In fact, the number of hospitals involved since the beginning in the reforms was possibly too large. If the experience is positive, the gains will be big, but if the experience fails, the costs are enormous. Opting for different stages in the transformation of public hospitals into hospital companies would have been a more cautious strategy. The research group that was created to follow the progress of the hospital companies (*Unidade de Missão dos Hospitais S.A.*) could have had more time to study the various changes introduced by the reforms and correct possible mistakes in order to make the experience as successful as possible. Parallel to this entity, also *Entidade Reguladora da Saúde* (see section 2) could give an useful insight to supervise the hospital companies, although the competences of this entity are still not totally defined at the moment. Furthermore, maybe it would be easier to make the medical staff accept all the changes involved. In fact, they have been contesting this initiative of the government and consider the results, so far made public by the Ministry of Health, as false results that aim only confusing the public once they give a too optimistic version of the reforms results.

But, on the other hand, if the number of hospitals would have been smaller, the impact of possible gains will also not be big enough to satisfy the government's objectives. There are some political moments where it is necessary to take 'big steps' and this was considered to be one of those moments. Some more time is needed in order to observe what are the results achieved by the Hospital Companies and to what extent they will address some of the problems identified by the government.

Up to this point, it was stated that the main reasons for the government to create the hospital companies was to increase the efficiency and quality of the services provided, while assuring cost containment. So, the *explicit rationale* underpins this reform and it is intention of the government to contain costs by reorganising some practices such as: introducing competition into the market, introducing individual labour contracts and introducing multi-annual contract programmes, amongst other. Nevertheless, *the implicit rationale* also plays a very important role: first the ideological background of the government; second and related with that, the introduction of professional management to reorganise some of the practices that exist within the hospitals and to reduce the discretion of the medical staff.

The first reason is obviously related with the fact that the government belongs to the right wing, and that influences its conception of what are the best solutions for the current problems that exist on the hospitals. Consequently, they introduced management principles used in for profit organisations. According to the Minister of Health this instrument does not mean privatisation of the public sector. Differently, it means introducing in the hospitals specialised and trained managers that are aware of the difficulties of running complex organisations. Furthermore, there is an intention to reconfigure the medico-management power relations, regarding that since the creation of the NHS, the doctors have had a very powerful position that has created some difficulties to the administrations of the hospitals (further discussed when analysing the 'Human Resources').

Once again, the political conjuncture contributes for the determination of the changes being introduced. It will be extremely negative if some of the reforms do not have continuity in the future, in case the current government does not win the forthcoming elections in 2006.

Pharmaceutical Policy

So far, the changes introduced in the pharmaceutical policy, had positive effects, considering that the public expense with medicines decreased in Portugal since generics were introduced. Nevertheless, it should be pointed out that there is a

negative effect associated with the introduction of generics: when a 'traditional' drug is prescribed by the physician or bought by the patient, and a similar generic exists, the 'traditional' drug is much more expensive than it was before (mechanism introduced by the government in order to encourage the purchase of generics). Consequently, if the citizens are not sufficiently informed, they can spend money unnecessarily.

It is then of maximum importance that information campaigns about the generics' market are addressed to the population, in order to assure that they identify the options that better suit them. It also important to make the doctors aware of the benefits to their patients in prescribing generics instead of the 'traditional' drugs.

The changes introduced in this sector are most of all related with the need to contain costs, therefore with the *explicit rationale* elements. This government reinforced the experiment of the generics that has already proved to be a success in other countries and the results have so far been positive.

Human Resources

Concerning the reforms introduced in the human resources, there are three main elements to be considered at this point that are interconnected: first the effects of the introduction of performance evaluation in the hospital companies, second the resistance of the personnel to change, and third the total number physicians and the allocation of human resources.

The government sees the introduction of individual contracts on the hospital sector and the performance evaluation as a possible way to reduce the costs related with the salaries of the personnel. The previously described experience carried out in *Hospital de São Sebastião*, with the introduction of individual contracts based on individual performance was successful, and the same can happen with the 31 hospital companies that are now operating. It is the belief of the government that there is a greater incentive to be productive and efficient, when the salary depends on it. Furthermore, those professionals that divide their time between the private and the public sector

because they have a fixed salary in the public sector and want to maximize their income by working in the private sector, have no longer reasons to do so. As well as in other of the reforms already described, the motivation of this initiative of the government is the reduction of costs, therefore part of the *explicit rationale*.

There are elements of the *implicit rationale* that have a very important influence over the changes introduced in the human resource policy: first the institutional weight that doctors always had in the NHS since its foundation and their consequent resistance to change; and second the situation in which the NHS was created, that originated a complicated and disorganised system translated in a deficient allocation of resources.

As far as the first element is concerned, there is an historical dimension that is very important and that is one of the explanations of why the doctors have a strong power position within the NHS. When the NHS was created in 1979 the total number of doctors was very small; consequently there was a high demand for new professionals and during the 80's there was a big increase in the number of doctors entering the NHS. As they were considered to be a very important (and scarce) resource, they were given a lot of power and flexibility to manage their professional life what allowed them, for instance, to work in the public and the private sector, being the first usually not a priority (as described in section 1).

All these doctors that entered the NHS in the decade of 1980 are still working now and due to the number of years that they have already worked there, they occupy important positions within the organisations. As they have been in the NHS for a long time, their resistance to changes is high, especially if that change interferes directly with their professional situation, by the introduction of mechanisms that can menace the status quo and that can be perceived as a downgrade in their professional situation. Furthermore, usually doctors do not like if the reforms' orientations are such that they intervene in patient related decisions. In this case, many doctors will quite likely attempt to subvert the system, perceiving it as an affront to their medical autonomy. Another dimension of this is that the current reforms will, in a way, alter the "power equilibrium" that has been historically controlled by the hospitals' medical staff, and that will now shift to the hospitals' administrators/managers. The reconfiguration of

the medico-management power relations is a very interesting subject that due to its complexity cannot be further analysed here.

Concerning the second element, it is argued in this paper that the current problems identified by the government as being the result of the bad allocation of human resources, are related with the turbulent situation (in political, social and economical terms) in which the NHS was created, shortly after the Portuguese Revolution. As already referenced, there was not a well-delineated plan in terms of distribution of medical staff throughout the country what made most part of them to establish themselves in the coastland health facilities. Additionally, there was a lack of appropriate organisational and management models associated with a lack of transparency between the public and the private interests, which made the all the system even more confuse and difficult to monitor. Regarding that in the last 30 years not a lot has been done to correct this situation, the NHS is now facing now big problems in reorganising its human resources.

Facing this situation, one of the main concerns of the government is to find a solution to the scarcity of human resources in the country. They proposed to develop an integrated information system in order to promote a better allocation of resources across the country. Apart from this, the government also wants to implement a project, together with the Ministry of Education, in order to increase the number of students that go each year to the medical schools.

It is indeed a problematic situation, the one that is being created in the NHS: a considerable proportion of the doctors will be in the retirement age in the next 10/15 years. But, according to data from the late 1990s (OECD, 2001a), the number of physicians per 1,000 population was 3.2 in Portugal, just below the EU average of 3.3. This data raises the possibility that the problem in Portugal is more related with deficiencies in the distribution and allocation of resources than with its absolute numbers.

The health professionals are mainly located in the urban areas around Lisbon, Oporto and Coimbra, while the rest of the country suffers from serious lacks of services in particular areas. For instance, the number of physicians in the Regional Health

Administration of Lisbon & Tagus Valley was in 2001, 4.1 per 1,000 population (much higher than the EU average) and in the Regional Health Administration of Alentejo it was 1.7 per 1,000 population (National Institute of Statistics, 2001). These asymmetries need to be corrected and that is more urgent than the increase of the number of students that enter a medical school, whose preferences might be to establish themselves in the big urban areas (because there are more opportunities, mainly in the private sector), thus aggravating the problem.

Conclusion

The main objective of this article is to describe the Portuguese NHS, giving a particular emphasis to the reforms that are being undertaken since 2002. For this purpose, it starts by giving an historical account of the creation and evolution of the NHS and then analyses the main actions that the government implemented recently in order to achieve what was defined as a 'New National Health Care System' that will direct the NHS in to a "mix of heath services, where public, private and social entities coexist and act in an integrated manner, direct towards the needs of health care users" (Ministry of Finance, 2003). The analysed actions are: the Public/Private partnerships, the waiting lists, the hospital management reform, the pharmaceutical policy and the human resources policy.

There is then a discussion about each of the reforms presented in section 2 that consists mainly in raising some issues that were still not addressed by the government and that can pose some difficulties in the implementations of the reforms and in achieving their goals. For this purpose, it is believed that it is necessary to understand what are the main motivations of the government when it decided which reforms to implement as well as understand what are the reasons that made the government do this, and not other type of changes. It is argued that there are two rationales underlying the options of the government: the *implicit* and the *explicit rationale*.

Both the *implicit* and the *explicit* rationale influence heavily the attitude of the government. Although one approach could be to assess which of these rationales has more weight in the government's t decisions, this was not the approach followed; what was understood to be more relevant was to comprehend that there are two different sets of reasons that influence the process of change that is now happening in the NHS. This is what is considered to be important because, if the motivations or reasons of the reforms are understood by the different stakeholders that are part of the NHS (staff of the NHS, public, politicians, etc) it is more likely that they get involved on them and that they face the reformation period as something necessary to the improvement of the heath system and not as a possible menace to their interests. For this, it needs to be clear what are the changes being undertaken and what are the

reasons to make those changes, so that all the players get involved, giving a special attention, at this point, to the doctors and the users of the NHS, because they are the ones that will feel, in a first stage, more intensively the changes introduced.

Another important aspect that can be assured by involving the key stakeholders in the reforms, is giving them continuity. The best way to guarantee the continuity of the reforms, even if there are political changes that can menace it, is to make the people that are part of the NHS to move it forward. It is indeed very important that errors from the past are not repeated and that the driving forces of the NHS are not anymore dependent on the political conjuncture and the Portuguese Healthcare system starts finally to have a sustainable development with a strong technical base.

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